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ORIGINAL ARTICLE / ARTICLE ORIGINAL

Potholes in the interview road with gender dysphoric patients: Contentious areas in clinical practice

Pièges et difficultés dans les entretiens avec les patients qui ont des troubles de l'identité de genre : points de controverses en pratique clinique

Trampas y dificultades en las entrevistas con los pacientes que tienen trastornos de la identidad de género : áreas de controversia en la práctica clínica

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KEYWORDS
Transsexual;
Gender dysphoria;
Clinical interview;
Sex-change treatments

Summary The mental health professional interview with a gender dysphoric patient is a unique clinical exercise. Here the patient makes the diagnosis and prescribes the treatment. The professional may be experienced as a road hazard to impede or detour the patient's journey to sex change. London's Charing Cross Clinic, the world's largest, remains committed to a cautious approach. Stages in gender transformation proceed from the safest, most reversible. The duration of the Real Life Experience (RLE) is two years. This paper presents transcribed interview extracts exemplifying potentially contentious areas between professional and patient. The extensive presentation illustrates the process whereby clinician and patient engage in these pivotal areas. An effective partnership should enhance the prospect of resolving profound conflict in sexual identity.
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MOTS CLÉS
Transsexuel ;
Dysphorie de genre ;

Résumé L'entretien du praticien de santé mentale avec un patient qui a une dysphorie de genre est un exercice clinique unique. Ici le patient fait le diagnostic et prescrit le traitement. Le professionnel peut être vécu par le patient comme un obstacle ou un risque de détournement de la voie du changement de sexe. La Charing Cross Clinic à Londres, la plus importante au monde, reste engagée dans une approche prudente. Les étapes dans la transformation de

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Entretien clinique ;
Traitements de changement de sexe

genre partent du plus sûr, du plus réversible. La durée de l'expérience de vie réelle est de deux ans. Cet article présente des extraits d'entrevues retranscrits donnant des exemples de points de controverse potentiels entre le professionnel et le patient. La présentation illustre le processus par lequel le clinicien et le patient s'engagent dans ces points charnières. Un partenariat efficace devrait augmenter la perspective de résolution de conflit profond dans l'identité sexuelle.
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PALABRAS CLAVE
Transexual;
Disforia de género;
Entrevista clínica;
Tratamientos y cambio de sexo

Resumen La entrevista del profesional de salud mental con un paciente que tiene disforia de género es un ejercicio clínico único. Aquí el paciente hace el diagnóstico y prescribe el tratamiento. El profesional pude ser percibido como un riesgo que impida o desvíe el camino hacia el cambio de sexo del paciente. La Charing Cross Clinic de Londres, la más grande del mundo, está comprometida con un enfoque prudente. Las etapas en la transformación de género van de lo mas seguro, a lo mas reversible. La duración de la experiencia de vida real es de dos años. Este artículo presenta extractos de entrevistas retranscritas con ejemplos de sectores potenciales de controversia entre el profesional y el paciente. La presentación ampliada ilustra el proceso por el cual el clínico y el paciente se comprometen en sectores bisagra. Un partenariado eficaz debería aumentar la perspectiva de resolución del conflicto profundo en la identidad sexual.
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Version abrégée

Les entretiens avec des patients qui se sont autodiagnostiqués transsexuels peuvent être un parcours d'obstacles. Rares sont les patients atteints de dysphorie de genre qui ont une incertitude quant à leur transsexualité. On se trouve dans le cas d'une consultation clinique au cours de laquelle c'est le patient qui pose le diagnostic et prescrit le traitement. De plus, beaucoup de patients sont réticents à consulter un professionnel de santé mentale arguant qu'ils ne sont pas « dérangés ». Le clinicien est un obstacle, un piège placé sur le chemin du changement de sexe[1].

Cet article présente des extraits d'entretiens (verbatim) entre clinicien et patients illustrant les domaines qui sont de fréquents sujets de discussion et de source de conflits. Les entretiens se sont déroulés dans la Gender Identity Clinic (clinique d'identité de genre) de l'hôpital de Charing Cross à Londres. Le service reçoit chaque année 500 patients qui lui sont adressés et assure la mise en œuvre de trois interventions de changement de sexe par semaine. D'abord, les patients ont un entretien d'une heure avec chacun des deux cliniciens sur une période de trois mois, ensuite tous les trois mois pendant une demi-heure, généralement avec le même clinicien. Les évaluations et les traitements sont pris en charge par la Sécurité sociale (National Health Service)[2].

La philosophie du traitement clinique est conservatrice. Elle se base sur les étapes les plus sûres et les plus réversibles. Ainsi, le changement de vêtements et de prénom précèdent le traitement endocrinien qui lui-même précède la chirurgie. Une période d'essai — généralement de deux ans — de vie réelle et complète dans le sexe vécu est exigée avant d'envisager la chirurgie. Cela inclut au moins une année comme employé(e) ou étudiant(e) dans le rôle de genre de la transition.

Les points fréquents de polémiques dans l'entretien portent sur les motivations douteuses du changement de sexe, l'ambivalence de la décision, les problèmes de diagnostic, les idées fausses du patient, la progression vers la chirurgie, les réalités de la chirurgie.

Les motivations du changement de sexe peuvent ne pas être celles essentiellement centrées sur un changement d'identité sexuelle. La principale motivation de certains patients nés de sexe masculin peut être le sentiment d'inadéquation à être un homme. Certains peuvent être victimes des stéréotypes de rôles sexuels. Pour d'autres, la vie en homme étant terrible, elle ne peut être que meilleure en tant que femme. Les patients peuvent avoir attendu de nombreuses années avant de demander une aide clinique. Cet aspect peut être le reflet d'une ambivalence vis-à-vis du désir de changer de sexe qui doit être évalué. Du point de vue diagnostic, le problème commun concernant les hommes est de savoir dans quelle mesure leurs expériences relèvent du transsexualisme ou du travestisme. Le pronostic pour le changement de sexe varie en fonction de ces histoires. Deux cliniciens doivent approuver l'intervention chirurgicale. Les résultats de la reconstruction génitale ne répondent pas nécessairement aux espérances du patient et la réponse sexuelle peut être compromise. Les personnes qui présentent des troubles de l'identité de genre n'ont pas toutes besoin d'un changement de sexe.

L'expérience clinique montre que bien qu'ils ne soient pas toujours d'accord avec le rationnel de cette politique, la plupart des patients la comprennent. Les activistes de la communauté transsexuelle critiquent l'approche conservatrice de la clinique. Toutefois, la fréquence espacée des visites des patients, le solide impact des propositions de traitements et leur irréversibilité et les résultats généralement favorables des traitements de la clinique parlent en faveur de ces stratégies qui servent au mieux les intérêts du patient.

[1] Interview recordings and transcription funded by ESRC grant RES-148-25-0029.

[2] An earlier, abbreviated version of this paper was written and presented by the author at the WPATH Conference, Chicago, Illinois, USA, September 2007, as ''Potholes in the interview road with gender dysphoric patients'', by Richard Green and Susan Speer.

Le traitement des troubles de l'identité du genre est un domaine de santé qui présente des potentiels exceptionnels d'amélioration du bien-être, mais également de potentialité de tragédie. Cliniciens et patients partagent les responsabilités d'un partenariat productif.

Full version

Introduction

The clinical interview with patients self-diagnosed as transsexual can be hazardous terrain. Few patients with gender dysphoria present with troubled uncertainty over whether they are transsexual. Here is the clinical consultation where the patient makes the diagnosis and prescribes the treatment. Beyond this, many patients resent having to see the mental health professional at all, insisting that they are not mentally ill. The clinician is an obstacle on the road to sex change.

The Gender Identity Clinic at Charing Cross Hospital, London, is the primary governmental National Health Service (NHS) facility for transsexuals in the United Kingdom. It accepts about 500 new adult patients a year. Its affiliated surgeons perform three to four operations a week. The Clinic has been functioning for over 40 years (Randall, 1969).

The Clinic is a tertiary service and accepts patients after referral by the general practitioner and a regional psychiatrist. The initial Clinic appointment is with a psychiatrist or psychologist and is one hour. The second is with another psychiatrist or psychologist and is also one hour. Follow-up appointments are 30 min, generally with the same clinician at each visit. Appointment intervals are about every three months. Patients may also have a consultation with the Clinic endocrinologist.

It is Clinic policy that cross-sex hormone treatment is not endorsed until the patient commences the full-time social gender transition. This Real Life Experience (RLE) prior to surgical eligibility is two years, but some female-born patients may be eligible for mastectomy after one year. During the RLE, patients must live full-time in the new gender for two years and work full-time for one year or be a full-time student for one year in the new gender.

This paper examines interviews between clinician and patient and identifies areas that are frequent topics of discussion that may be a source of conflict between clinician and patient. Interviews follow an open-ended format. They do not proceed from a written list of topics. The interview segments reported here derive from a pool of 180 sessions recorded over a two-year period. They were selected to illustrate common sources of conflict. Interviews were conducted by the author. Each is with a different patient. Topics are grouped into: questionable motivations for sex-change, ambivalence over sex-change, diagnostic issues, patient misconceptions, progression to and realities of surgery, and admonitions.

To generate the interview transcripts, Clinic patients were given an information sheet about the recordings. Nearly all agreed to participate and provided written consent. The project was approved by the Hospital and National Health Service Trust Human Subjects Protection Committee.

Interview examples

Questionable motivations for sex-change

Motivations may not be those based essentially on a cross-sex identity. For some, feelings of inadequacy as a man may be the driving force.

Patient: I've always felt a degree of inadequacy when I've been with other blokes if you like. It seems like that you're trying to go one stage better, you're trying to project yourself, almost prove something, and it's almost to be as good at, try to be as good as they are, but I've always felt almost inadequate with the men.
Psy: Inadequate, in what way?
Patient: Well, maybe not as good as they are, you know, physical stature, strength.
Psy: That's very common among men.
Patient: Yeah.
Psy: Many men feel inadequate compared to other men — that's why they go out and get tattoos, lift weights and drink a lot of beer because they don't feel adequate as men. That's very common. It doesn't mean they have to change their sex though.

Some may be victims of sex-role stereotypes.

Example 1

Patient: It's been there for as long as I can remember and it's been suppressed.
Psy: What is the ''it'', try and describe the ''it''.
Patient: The feeling that I don't fit in. The feeling that I don't belong to the group of people to whom I've been assigned, namely males, that's always been there, and it's been a real struggle for all my life.
Psy: What do you mean you don't belong to the group?
Patient: I don't particularly like the company, I don't like the things that most men do. I'm not interested in any of those sorts of things.
Psy: Such as?
Patient: Cars, football, anything like that. A car is something that gets me from A to B.
Psy: Have you ever met a man who did not like cars or football?
Patient: Not many, no. Some, I agree, there are some. I know I'm not unique in that way. But, if I'm in a group of people, and there are men talking about things and there are women talking about things, I know where I'd rather me. I'd rather be talking about things that women talk about.
Psy: And what sort of things do women talk about that you find?
Patient: Dresses and clothes and hairdos and all that sort of thing. I can't explain it, I don't know.
Psy: And the men are talking about what?
Patient: Oh all the things they get up to. And if they start having too much to drink they start talking about what they'd like to do with women. I just can't handle it, I don't like that at all. It just doesn't fit, I don't feel part of that at all.

Psy: I hear what you're saying, but it sounds like you have a fairly black and white stereotyped sense of what men and women are without any greys between them.
Patient: Yeah, that I think has been part of the problem because we have this binary view of the sexes men do this, girls do that.
Psy: Some of us have.
Patient: Yeah, okay, right, I accept that. But the general world view seems to be very binary and although I think that is changing it is still men do one group of things, women do another sort of thing. And I just don't fit it. I went to an all boys school and I hated it, every minute of it.
Psy: A lot of boys do.

Example 2

Patient: Every man in my family has got a huge beer belly.
Psy: Ok it doesn't mean it has to be yours.
Patient: But it does because I'm expected to be the same.
Psy: You expect to have a beer belly, why?
Patient: Because everybody else does.
Psy: Well, I mean that's up to you if you want to have beer belly; firstly you're not going to live in your house with your family there for the rest of your life you can move out and be on your own at some point, and because your father and all men in the family have beer bellies that's not necessarily a very positive role model to follow; it doesn't mean you have to have a beer belly. There are certain things about being a man in your family that you don't like, which I can understand.
Patient: Yeah.
Psy: And the thing that I'm a little confused and even troubled by is the issues of what you saw as a considerable degree of life expectation in your household and a life-style commitment to being a beer belly whatever; and I can see why a lot of people would rebel against both of that but that doesn't necessarily mean the same thing as becoming a woman; it means becoming a different kind of man, so I don't understand how it leads you to thinking, that you need to be a woman.

Or, life has been terrible as a male.

Patient: You see I'm getting on in life now, forty-seven, and I've just got to do something, I've got no way out. I've got nowhere as a man all my life — so I want the second half of my life to try and do something, try and be happy.
Psy: Well, you've got nowhere as a man, it doesn't guarantee that you're going to get somewhere as a woman.
Patient: No. I can only try.

Ambivalence over sex-change

Some patients contend that they have suffered from gender dysphoria for many years, yet did not seek information or come forward for clinical assistance.

Example 1

Patient: To me it's not, it's not just a bit of fun dressing up in women's clothes.
Psy: Well no one's saying it's fun, it's just the question that you've been telling me that it's really important that you be a woman but you haven't really done very much about it for about 35 years. So I'm trying to understand how important it is for you.
Patient: Well it's very important.
Psy: If you haven't done anything about it.
Patient: Well I've been, I've been depressed, I've been ignorant, I've been frightened to, I mean for a long time you know I thought I was a freak. You mentioned that this clinic has been here for 50 years.
Psy: Since the late 50s, yeah.
Patient: Yeah, I knew nothing about that.
Psy: Thousands of people knew about us, but you didn't and I don't understand why?
Patient: Um, well I've, I've been very secluded.
Psy: Where were you living?
Patient: I'm living with my mum, but I haven't really had friends or, or contacts. I've quite reclusive.
Psy: You don't read books, magazines, watch TV?
Patient: Yes I read books and magazines, I found out about a, a place in, I found out about a gender place in Manchester I think or something like that. I've been making enquiries as best I can.
Psy: When did you find out about the place in Manchester?
Patient: Oh this was years and years ago. I actually wrote off, about when I was about 26.
Psy: 10 years ago.
Patient: Yes.
Psy: And they replied I presume?
Patient: Yeah, it was a private clinic.
Psy: And did you see them?
Patient: No. I couldn't afford to at the time.
Psy: I'm just puzzled why you haven't done anything about it for over 30 years.
Patient: Um, I didn't know a great deal about what options were available to me.
Psy: I'll accept that, I'm still puzzled why you didn't look into it more thoroughly since it was such an important thing for you.
Patient: Well I did, I did look into it I looked into it as far as I could. I had to reveal this to my mother, I had to reveal this to my sisters. And I had to, and that was a, a great emotional turmoil. I have been looking into things and like trying to find out what is available.

Example 2.

Psy: Why did it take you 30 years to get here to this clinic?
Patient: Being honest with you, I'll tell you why, because one I thought I had to be a certain age, I thought I'd be too young to even say anything.
Psy: At what age do you think in this country you become an adult?

Patient: I know you're legally adult like 18, between 18 and 21, legally.
Psy: 16, 18, okay.
Patient: Okay but for me, the reason why it's taken me so long is that, it's not that I had to make sure, I've been through a hell of a lot, my mind was over a hell of a lot, I'd gone through quite a few things.
Psy: Try to explain them.
Patient: I went through serious racial abuse, physical abuse, not violation, but just physical abuse. There's been that most of the time, I was bullied at school.
Psy: Okay, but why would that prevent you from coming forward with your wish to be a man?
Patient: I wasn't thinking about it, even though I behaved and did whatever as a guy, my mind was already preoccupied. I didn't even think about that, I wasn't thinking about that just yet, I was so preoccupied with trying to sift through all the things in my mind. Also I was scared cos I didn't, I thought, honestly and truthfully I thought that maybe I would get turned away or no one can help me. So I kind of tried to continue my life to the best way I knew how. But the more I got older, the more difficult it became, the more difficult it became, the more depressed I became, and the more depressed I became, the more I edged towards suicide, it was a case of me wanting to free my soul from this body cos it felt enclosed, felt imprisoned.
Psy: I understand that, it's just that it's unusual, somebody with this distress about this wouldn't have come forward. This clinic's been here since the 1960s.
Patient: I didn't know that, I wasn't aware of it.
Psy: Thousands of people figured that we were here. So I'm just wondering why you didn't know it if they all knew it.
Patient: I didn't, I didn't know, honestly I didn't know. I was, I was afraid.
Psy: And you were feeling uncomfortable being a woman, a female?
Patient: My mind was preoccupied with a lot of things, I didn't even have a chance to think about myself, about how I felt. I just went on as normal, doing, being me. And the more I was me, the more people could see there was something different about me.
Psy: What could they see different?
Patient: My mannerisms wasn't female, the way I did things wasn't female, the way I spoke was not female, just the way I did things and how I did things and the way I thought, the way I think.
Psy: Uh-huh.
Patient: I think it has also probably taken me a long time because it was something my mother had to come to terms with. Because to her I was a girl, I was her daughter. And she kind of made me feel a certain way where I couldn't come because she'd done so much for me, I felt indebted to her, so I didn't want to upset her. But when I had finally got a chance to sit down and talk to her and explain to her how I actually felt as a person and what it was doing to me, she came round, she understood, she took time out to hear what I was saying.
Psy: That's still a long time ago. I'm still trying to figure out why it took you all these years.
Patient: I believed that I wouldn't be helped.

Example 3

Psy: The clinic has been here since the middle sixties.
Patient: Well. . .
Psy: And we've seen thousands of people. They found us, but you didn't.
Patient: I did find you in the end.
Psy: I'm puzzled why if it's such a big issue in your life you waited all of these years to do anything about it.
Patient: You bury yourself in work and you do everything to try and. . .
Psy: You buried yourself in work for 20 years?
Patient: Everything to try and hide it, sort of keep it suppressed.
Psy: Tell me how you buried yourself in work for 20 years.
Patient: I just worked seven days a week basically.
Psy: What kind of work do you do?
Patient: I was a builder. Yeah, and I used to work on the farm on the weekend.
Psy: Now I understand what you're telling me right now, but I don't understand why for 20 years you were able to not deal with it, just go to work. It doesn't sound like it was all that big an issue from that.
Patient: I think it was, you see I've spent all my life working, like I said I've buried this with work.
Psy: It sounds like you buried it pretty deep for a couple of decades, that's a long time.
Patient: Couldn't have been good for me.
Psy: Whether it was good or not but you did it. I mean you kept working.
Patient: Seven days a week.
Psy: You lived as a man so it couldn't have been all that terrible, you did it for a long time and you seem to be successful, you have a job, presumably had friends?
Patient: I do have to bury it, yeah.

Diagnostic questions

A common issue in assessing male-born gender dysphoric persons is the extent to which their experience represents transsexualism or transvestism.

Psy: Your history as you've given it, to the doctors here is not entirely typical of someone who wants to change sex. To some extent in the past dressing in women's clothes has been a sexual turn on. Is it still?
Patient: It would depend on the style.
Psy: It could be. I mean the extent to which female type clothing is a sexual turn on for men, signifies more in terms of transvestism than transexualism. And for transvestism to be operating, you have to have a substantial male identity, male quality

to you, okay? Which is why you get the erections to the dressing. And to the extent that you have male components in your make-up, you don't want to have your penis cut off and have sex change surgery, cos the outcome isn't always very good. Okay? People who come out of a transvestic background, and what goes along with that is a sexual interest in females, that's all part of the same picture. Experience shows that yeah they can do well with sex change surgery, but there are more problems than in someone who has been extremely feminine, has only been sexually interested in male partners, has never had sexual arousal from cross-dressing. So there are different types of people who come to the clinics like this. Now it doesn't mean that you're not going to be able to get what you think you need now, but what it does mean is we have to be very cautious in the real life test, with the RLE. And two years is a minimum period and if there's any question still, we want to be careful.

Patient: Okay.

Psy: People regret surgery, and the people who regret surgery are very often those who run into it too quickly, more often people come out of more of a male type transvestic background. Every once in a while there is a guy comes in here, who had his penis cut off somewhere and then regrets it. Usually it's not from this clinic, usually it's someone who got enough money, which fortunately you don't have to go to Thailand, fortunately for you you're broke.

Patient: (Laughs).

Some male born patients have been masculine boys. This raises concern about the extent of their feminine identification.

Example 1

Psy: You were a reasonably conventional masculine boy.

Patient: That's correct, yes.

Psy: That's of some concern in terms of whether what you are proposing now is necessarily going to be that successful. Because it means that there's a certain amount of you that's quite male and masculine and the extent to which it's there interferes with living full time as a woman.

Patient: I don't understand.

Psy: If you were a very feminine little boy and always felt that you were a girl, needed to be a little girl, and you were obviously feminine, okay. Those people if they come in here at 15 and at 20 or whatever, have never shown any hint of maleness and masculinity. And their psychology is so female and feminine that it's, it's obvious that they're going to do well living full time as a woman.

Patient: I see.

Psy: That's not your history.

Patient: No. No, it's not.

Psy: Well probably it's wiser to see what it's like living as a woman.

Patient: Oh sure, yeah.

Psy: Because you may decide you don't want to.

Patient: I understand that.

Psy: Your background is as a masculine boy and a transvestite, which has a lot of masculinity and maleness in it. And that's a barrier to living successfully full time as a woman, so you need to decide very, very slowly whether it's going to work for you.

Patient: Absolutely, it can't change my genetic composition. Neither can the 15 or 20 year olds I suspect who come and see you and in your opinion are more worthy of treatment.

Psy: Not more worthy of treatment, they have more femaleness about them.

Patient: Well it's a subjective opinion Professor, if I may say so.

Psy: And the research shows that they do better in the long term than people who come in later in life with a masculine background. In long-term follow-up studies they do better.

Patient: Well it doesn't surprise me really.

Psy: So that's more than opinion, there's actually evidence out there.

Patient: Well it's evidently obvious if I may say so Professor from observation, because they will not have carried the masculine baggage.

Example 2

Patient: The big issue for me when I was a young lad was actually leaving home and getting a job and standing on my own two feet.

Psy: Okay, that's important, but it's just not, it doesn't show that you had a major gender identity issue.

Patient: No. No.

Psy: And that concerns me.

Patient: No I just, when I was younger I just tried to do what everybody else did. I just tried to be normal.

Psy: But you weren't that normal either, you were a difficult person with a multiple prison record. All those things don't necessarily reflect somebody who feels like he should have been born a woman.

Patient: Yeah, even when I was at school I was what we would call a bit of a rum lad.

Psy: Yeah, that's not very girlish, that's what concerns me.

A patient's reported long-standing gender dysphoria may not be corroborated.

Patient: It all started off when I was say about six, seven, when I was playing with my cousins with dolls and dressing up as women, like doing what the girls...

Psy: Six or seven, you remember that?

Patient: Yeah.

Psy: Can you prove it?

Patient: No.

Psy: Do you have any pictures of yourself dressed as a girl?

Patient: Not on me, no.

Psy: Anywhere, anywhere in the world? Are there any pictures of you? You were six and you said you were dressing as a girl and playing with dolls. Is there any way you can prove that really happened?
Patient: No.
Psy: Nobody has pictures of you doing that?
Patient: I don't know what my cousin's done with them.
Psy: Who took pictures?
Patient: My cousin.
Psy: When you were six.
Patient: Yeah.
Psy: Of you dressed as a girl?
Patient: Yeah, but I probably think she might have thrown them out.
Psy: Why don't you ask? Find them if you can. Because you cannot tell us that you were like this at six, just telling us doesn't prove it.
Patient: Yeah, I know.
Psy: So at six or seven you were feeling like you wanted to be a girl.
Patient: Yeah.
Psy: Who did you tell about this?
Patient: I told, I actually told my mum.
Psy: You told your mum when you were six or seven.
Patient: Because she found out herself because I was down my cousin's and I went up to my mum's and my mum seen me.
Psy: Dressed as a girl?
Patient: Yeah.
Psy: And what did she say?
Patient: She said take them off now, and everything like that.
Psy: Does your mother remember this?
Patient: Probably, yeah.
Psy: Because your mother was seen with you when you saw a different psychiatrist before you came here. She was there for part of the interview with you. And she didn't say anything about seeing you dressed as a girl when you were six.
Patient: I don't know, didn't she?
Psy: No, the doctor sent me a letter describing the interview and said that your mother was there for much of it, but that your mother was quite surprised recently when you said that you want to become a girl.
Patient: Yeah.
Psy: So if she had seen you dressed as a girl when you were six why would she still be surprised?
Patient: I haven't got a clue.

Treatment misconceptions

Many patients want to commence cross-sex hormone treatment before they embark on the full-time gender transition.

Psy: Okay, so this is your first visit here.
Patient: My first visit, yes.
Psy: And what are you hoping to accomplish today?
Patient: It would be nice to go home with hormone tablets because I'd like to become more female than I am now.
Psy: And is it your understanding that you would be able to start hormone tablets today?
Patient: Yeah.
Psy: You didn't receive any information from us about the procedures after having been referred to us?
Patient: No, no.
Psy: Because you signed something here that you sent back.
Patient: That's right, yeah, yeah, that's right.
Psy: And what did it say... you agreed to this, what did it say about hormones, do you remember?
Patient: Um, I can't remember because it was some, some weeks ago.
Psy: It said, hormones may be prescribed after your first two consultations, and if you're a smoker you must stop smoking for three months. And it smells to me like you smoke quite a lot?
Patient: I do, yeah.
Psy: So obviously there's no way you're going to start hormone tablets today. I'm not trying to scold you, but why wasn't that clear? You haven't stopped smoking and this is your first visit so why did you think that you might start hormone tablets today? There's a process you have to go through, okay? So at some point you might be eligible for hormone tablets.
Patient: Yeah.
Psy: We'll see how that goes.

Patients may demand cross-sex hormones early in assessment with misinformation backing the demand.

Patient: I'll stay and live as a fairly unhappy male, but having said that I would like the opportunity of going on to loads of hormones to see what the effect would be, although it's frowned upon in the medical profession, I believe.
Psy: Why would you want to see about female hormones?
Patient: Because I feel as though I need them.
Psy: What do you mean you need them?
Patient: Well, I do actually believe I've a female brain. I've done a lot of research into it and read a lot about it and I think it would be beneficial.
Psy: To take female hormone tablets.
Patient: Yeh because I'm not going into a lot of details... you know I read here that ''vaginas, basically erm (reading quickly from paper...)'' I feel, I might be, that may be me.
Psy: Maybe; that's not generally how the Clinic works.
Patient: I know.
Psy: That's the problem.
Patient: I know, I know all about that so maybe I was thinking although according to my doctor even a low dose hormones, eventually it's inevitable that it would feminise me to some degree.
Psy: Yeah it would have some feminizing affect. Let's say you were on a low dosage of female hormone for a year, what would you expect to change about you?

Patient: Mentally, I think I'd be a much better, I think I'd be a happier person.
Psy: You'd be happier mentally, why?
Patient: I'm not a doctor so it might sound contradictory, maybe...
Psy: Why would you be happier?
Patient: As I said to you, I don't feel happy being male.
Psy: Taking a female hormone tablet a day wouldn't make you female, so what would change?
Patient: I think it would change the mental aspects.
Psy: Like what, what do you think it would change?
Patient: I just think I'd be a happier person.
Psy: By swallowing a female hormone tablet?
Patient: Yeah. Love to break skepticism on your face... the research I've done indicates that a person — the interview I got this off the Internet what I have here — ''if a person, if a male does in fact have a female brain, the brain is waiting for the female hormones''.
Psy: Well, I can just say in response to that, that the medical profession doesn't really agree that people have a male or female brain.
Patient: Oh I know; I know it's not absolute.
Psy: So that, that's not going to fly very much in terms of a university hospital; the question is will the hormone treatment make you feel that you are doing something productive by taking the tablets.
Patient: Yeah, it would it would be, I think of pushing me in the direction I'd really like to go in. I also realize that opens probably a can of worms.

An absence of sexual attraction to males will probably not change.

Psy: So if you were going to have a relationship in the future, what would it be like do you think?
Patient: Good heavens above. I don't know. I mean I see, if I'm honest with you I see myself as, I see myself as the woman, the, the wife, the looking after the home, going out to work...
Psy: With a male partner or a female partner?
Patient: Probably male partner I would imagine.
Psy: You find males sexually attractive?
Patient: I don't really.
Psy: Have you ever found males sexually attractive?
Patient: Um, no, not massively. No, not really.
Psy: Why do you think that will change?
Patient: I guess because being fully female if you like, having the, the full female body and being who I really am, the acceptance if you like of, of who I actually am.
Psy: So if you have a female body you have to have sexual interest in males?
Patient: No.
Psy: What about lesbians?
Patient: I don't think about it, doctor, I don't... I don't know.
Psy: I'm just wondering where your idea that you're going to find males sexually interesting comes from when they've never been sexually interesting in the past?
Patient: I don't know, I mean I, I would have said to myself that if I, if I fancied men then I'd, I would have assumed somehow that I was gay.
Psy: In the past you've always found females sexually attractive?
Patient: From an early age I was brought up with the, the boy this, boy that, and my family consists of four girls. My father always wanted a son. It was son this, son that. So basically I did what was expected of a son.

Admonitions

Overweight patients must lose weight.

Example 1

Psy: When was the last time you tried to lose weight?
Patient: Um that was about two years ago I put a really big effort in but I think I was hampered by the thyroid problem, I just, just tried to diet and it just wouldn't come off. But now like it's like the thyroid problem that's going to give me an incentive to actually go.
Psy: How much do you weight?
Patient: About 22 stone I think actually.
Psy: And how tall are you?
Patient: I think about 5′ 11″.
Psy: I'm just wondering whether it makes sense to refer you to the surgeons at this point because they're just going to tell you you've got to lose weight.
Patient: Oh well no I mean obviously not, no, no, it wouldn't make a great deal of sense.

Example 2

Psy: Now do you understand about the weight problem and surgery?
Patient: Yes.
Psy: What's your understanding?
Patient: I need to lose weight before I can actually have surgery.
Psy: How much do you think you need to lose?
Patient: I'd say all of it, I'd have thought, all of the excess fat.
Psy: Yes, they won't operate if you're overweight. Do you know why?
Patient: Well I presume it's like with any, anyone that overweight surgery becomes pretty difficult.
Psy: Surgery becomes technically difficult, the medical risks are much greater. The anaesthesia deaths are higher. So you have, you've got to take a lot of weight off.
Patient: Yeah.

Self-harming must stop.

Psy: In the past you've had problems with depression I understand?
Patient: Yes.
Psy: Tell me a little bit about that.

Patient: That was more a conflict of interests between me as Jane and what society was saying I should be like. And as I accepted Jane more I was able to come to terms and work through.
Psy: And how do you feel the depression issue is with you now?
Patient: The depression is under control.
Psy: What do you mean, under control?
Patient: Well I'm not on any medication, I'm happier than I have been.
Psy: Okay, good.
Patient: I've not harmed for a long time now.
Psy: How long has that been?
Patient: It's since before Jane actually came into being full time. I was told then that I had to stop cutting because if I didn't that would affect any possibility of going for surgery.
Psy: Why do you think that's the case?
Patient: Because I was at risk still. I was seen as unstable.
Psy: Yeah, and why would that have affected the surgery?
Patient: Because they would feel that I had not come to terms completely.
Psy: We like to think if you're living as a woman it's working for you, but if you're still hurting yourself, living as a woman isn't going to do it for you. If people still have big psychiatric problems while they're trying in the new gender then maybe the new gender isn't all that they'd hoped for. So you have to show that you're living well before the surgeons will be prepared to do the surgery. Does that make sense?
Patient: Well as far as I'm aware I am living a lot better than I have done.
Psy: Yeah, I agree, but I mean do you understand why the clinics and the doctors feel that way?
Patient: Yeah. If, if it's not right and they've done it and you want to go back it's a waste of time because you're not going to get your parts back.
Psy: Yeah, and more than a waste of time it's a personal disaster to the patient.
Patient: Of course.

Referred for psychotherapy.

Psy: I referred you to see a psychotherapist. Have you had any appointments yet?
Patient: Yeah, I've had a few. I think two, two or three.
Psy: And what have they been like for you?
Patient: I didn't really find them that helpful really. You know I didn't really, them sort of I just find it a little bit too hard to explain things to him, I couldn't, I just sort of, in a way sort of just played along with what he wanted me to sort of say really.
Psy: What do you mean, what does he want you to say?
Patient: I don't know. I suppose you know he was just saying that you know he thought I looked very masculine. I mean it did upset me but I just sort of played along with that really.
Psy: Well it's not a question of playing along. The thing of it is that you need some help in understanding more about yourself and you're not going to get that here. That's why I referred you to a psychotherapist, an experienced psychotherapist. How many more appointments do you have?
Patient: I think he's making me another appointment soon, but he hasn't actually confirmed it yet.
Psy: Good, because if you're going to trial living as a woman you need to get some handle on what it is that's happening with you, right?
Patient: Mmm.
Psy: They also have a group therapy program for people who are very conflicted about what to do just like you are in terms of whether they should do any kind of gender transition. You go as slow as you want. You can be our patient for a thousand years if you want.
Patient: Thanks. It's just that I still find things hard to explain to him.
Psy: It will get easier over time. But coming here ever three or four months is not going to really help you explain it.
Patient: Yeah.
Psy: Okay? So if the chance comes for group therapy take it.
Patient: Yeah.

Progression to and realities of surgery

Female-born patients also need to know the progression of treatments and their rationale.

Example 1

Psy: How long do you have to be before, what do you have to do before you start getting operations?
Patient: I don't understand that question, sorry?
Psy: We're not giving you an operation this week, why not? We're not going to do it this month, why not? Do you understand how the process works?
Patient: I come to see you a few times or. . ., or other doctors. A few times, and then we talk and, and then we go from there. I know it could take years.
Psy: What is the next step after talking before anything else happens?
Patient: I don't know.
Psy: Some of this was explained to you at the last visit. The doctor went over this with you.
Patient: She said to me sort of like to have my breasts removed and then to start the hormone treatment.
Psy: What sequence did she say that would happen, if it happens at all?
Patient: To have my breasts removed first.
Psy: Before the hormones?
Patient: Yeah, because she said it wouldn't be fair for me to walk round with a beard when I've got breasts.
Psy: She couldn't have said that because the clinic doesn't work that way.
Patient: Okay. So maybe I misheard her.

Example 2

Psy: And so the treatment approach is to do reversible steps as best as they can be reversed before the absolutely irreversible.

Patient: Right, okay.
Psy: You can change your name back again.
Patient: Yeah.
Psy: Every day if you want to, you can change your name ever day of the week.
Patient: Yeah.
Psy: You can change your clothes, if you want.
Patient: (Laughs).
Psy: That's easy to do, right?
Patient: Yeah.
Psy: If you start taking hormones some body changes are going to take place. What are they?
Patient: Well your voice gets deeper. The other doctor said sometimes your body changes, like your shoulders sometimes get broader.
Psy: It depends how much you work out.
Patient: Yeah, and start getting facial hair.
Psy: What will it do to your sex life?
Patient: I don't know, hopefully make it better, be normal.
Psy: How will it make it better?
Patient: Because I hate my body at the moment.
Psy: Yeah.
Patient: And when I'm with my partner she doesn't see me naked.
Psy: One of the things that male hormones do is to increase sex drive, you get hornier.
Patient: Yeah.
Psy: How do you feel about that as a possibility?
Patient: (Laughs) it will be good won't it (laughs)?
Psy: Your sex drive may well go up, your clitoris will get larger, you'll want to have sex more. Would that affect your relationship in a good way or a bad way?
Patient: In a good way.
Psy: And some, some things will happen maybe that you won't be happy about. Have you got any idea what they are?
Patient: Mood swings?
Psy: Probably not. You may get acne.
Patient: Acne, yeah, yeah, she mentioned that.
Psy: You may go bald.
Patient: Bald?
Psy: Yeah, men lose their hair, you know how they lose their hair. They have male hormones. People with male hormones lose their hair, it depends on your genetics. You may go bald as a man would.
Patient: Okay.

Two clinicians at the clinic must endorse surgery.

Example 1

Psy: Well, this is what has to happen. Two doctors here have to approve you for surgery.
Patient: One already has and you're the second.
Psy: Who has approved you?
Patient: The last one I saw.
Psy: She approved you for surgery?
Patient: Yeah.
Psy: Our experience is that no one on the very first visit actually ever writes an endorsement for surgery.
Patient: Right, pity this isn't disclosed to the patient because it's not what I was told. You know, this is very clinically based, looking at patients, it's not really like patient led in a sense — you're not looking at how I feel or what the issues are surrounding my life that made me come to this point. I don't see how you can assess within an hour all the implications and all the difficulties that I've had previously, where I am.
Psy: Of course not.
Patient: And the fact that I came, I've waited and gone through one trip up here and talked to one psychiatrist about this issue. Originally, I've seen about four or five other psychiatrists and even had a psychological assessment of myself. I don't want to be 60 when this thing happens. Well, I could just go privately then, you know, if I could come up with like ten thousand grand and you'll do it, which seems, which is unfair.
Psy: I think you should stay in the NHS and get the taxpayers to pay for it
Patient: I might have to wait until I'm 60 before I have, it happens.
Psy: I don't think you'll have to wait that long.

Example 2

Patient: Don't you think it's very painful for patients the type of clinical based practice you're doing here in a sense that you take over, you're not listening to clients.
Psy: The international standards of care require that two consultants approve the surgery after the RLE is documented.
Patient: Right
Psy: Those are the minimum criteria.
Patient: I understand but that was never ever disclosed to me. That's never been put, I have some meagre bit of information on a sheet more like a dictatorial list of things I shouldn't do when attending the Clinic — nothing about the procedure, or what the timescale might be or what could I expect by coming here and meeting you guys.
Psy: All I can say this is the way the Clinic works, what the procedures are and this is what the Clinic does and this is what the Clinic's been doing for decades. Those are international criteria for referrals for surgery.
Patient: It doesn't make it right for the people you're seeing though.
Psy: Well, we think it's the best way to proceed.
Patient: Without disclosing any information, that's terrible.
Psy: We think we did. I can't change the Clinic policy sitting here today.
Patient: No, no, I wasn't expecting you to, but I have, obviously I have a right of voice, I am seeing you. It does say ask your psychologist if you're having any difficulties, which I'm expressing my concerns.

For a female-born patient, possible top surgery in a year, bottom surgery in two.

Psy: And in terms of other surgeries — do you have thoughts about any other surgery at some point you might want?
Patient: I want the bottom half done.
Psy: What do you understand about that?
Patient: I can't remember. I know I watched that programme with them four women. And they showed one of them having the bottom part done, but I'm not really, it's a bit vague now what they'd done.
Psy: What makes you think you wanted that? If you're not sure what it is, why do you want it?
Patient: I don't see the point in having half done when I'd sooner have it all done.
Psy: I see. After a year or two then you can discuss that more with the doctors here and the surgeons. The bottom surgery you wouldn't be eligible for, for about two years; the breast surgery, which is really important to you, after a year. How much of a problem is having female type breasts for you at this time?
Patient: A lot at the moment.
Psy: A lot of trouble, in what way?
Patient: Mainly when I wear tee shirts and that, I wear about four or five. And when it's nice outside like in the summer, I still wear a lot of tee shirts. I just hate it.

Results of phalloplasty.

Psy: What would make you not a woman?
Patient: If I had a penis.
Psy: If you had a penis?
Patient: Yeah, it would make me a man.
Psy: Okay, and what do you know about getting a penis?
Patient: I don't know anything.
Psy: Do you swallow a pill?
Patient: No, no, surgery, surgery.
Psy: And have you ever talked to anybody who's done that? Have you ever looked on the Internet?
Patient: Yeah, but I didn't find much information really that I thought would be correct.
Psy: What do you remember?
Patient: People saying that they'd been on hormone treatment before and they've had surgery to make a penis. And that's what I've read.
Psy: Okay. I'll give you a short lesson on that which you don't have to worry about today, but just to give you some information so you have more than you have. In the last 10 years doctors have done a lot better in terms of surgically creating a penis. It's a lot of stages of surgery, it's not just one operation. At its best it doesn't look exactly like a penis that was born on someone, it looks different because there's all the surgery involved. Depending on the kind of penis that's built and where the penis tissues come from it's possible to stand to urinate through the end of it. Other ways of making a penis you still have to sit down to urinate. There's very little actual feeling along the length of the penis.
Patient: Uh-huh.
Psy: But the sexual feeling where your clitoris is now remains. And in terms of having sex with the penis in terms of it's getting rigid enough to go into a vagina there's an implant, something put into the penis and the scrotum, the testes, that allows it to become erect with the fluid that gets pushed into the penis which makes it stand up somewhat and gives it enough rigidity to penetrate into the vagina. Okay? So at its best it doesn't look exactly like a penis and at its best you can urinate from the end. At its best you can use it for intercourse but obviously it's not, it just doesn't get erect looking at a sexy woman like it does for a lot of men. So those, those are the limitations.
Patient: Yeah.
Psy: So having heard that, what are your thoughts about it?
Patient: But I feel like a man, I know I'm a man inside.
Psy: Yes, I understand.
Patient: Inside, but not.
Psy: Okay, but in terms of your body, would that make you a man enough that you'd be comfortable having sex as a man with.
Patient: Mmm.
Psy: That would be alright, even though it's not perfect.
Patient: No, because I'd be with a partner who would understand me. I'd have to be with somebody who would be able to accept it.

Not all male gender dysphoric patients need surgery.

Psy: Some people live very effectively as women, which I'm sure you will do, because you present very effectively. Some people will live very effectively as women without surgery and decide that's what they're going to be doing and some people feel that it's absolutely imperative that they take the risks and involve the surgery. And there are risks, I mean it may not go well; may not function well; may not look good; you may get a major infection, on and on.
Patient: Anesthetic itself is quite dangerous isn't it?
Psy: It is elective surgery; not like you have to have it done or you'll die of cancer, its elective surgery in that sense. But you don't have to worry about that today; you're just beginning the RLE. In your case the actual gender dysphoria element is fairly late onset and so I think you need to be cautious about that aspect of it; it's not to say that your need to dress and appear as a woman is going to go away, it's not going to happen.
Patient: Hmmm.
Psy: But whether the need to change your body dramatically with all the consequences of that.

Sexual feeling postsurgery.

Example 1

Psy: What about functionally sexually, what would you expect from that?
Patient: I know that you can give some sensation through an artificial clitoris, that's what I've read.

Psy: Well do you expect to have full sexual arousal and sexual climax?
Patient: I, don't know about that.
Psy: How important is that?
Patient: It's not that important to me actually, no, it's not that important. It's more important to actually get rid of what's there.
Psy: Many patients don't have full sexual arousal because of all the cutting and scarring and so on.
Patient: Mmm.
Psy: Is sexual climax an important part of your life?
Patient: No it's, it's, definitely not. That's not a problem.

Example 2

Psy: Do you think you get as much sensation lets say, enough to achieve sexual climax as a woman, or wouldn't it be that much?
Patient: I wouldn't know; but I'd like to think so; it would be nice but, again, you know, its not just about having sex its about being happy with your body. If I meet somebody that's nice then that's fine. That's just a bonus to me, I just want to be happy with my body.
Psy: I understand that but it's just that some people go into the surgery with somewhat unrealistic expectations as to what it's going to be like sexually.
Patient: Hmm.
Psy: And a lot of people are convinced that they're going to have sexual climax or orgasm after the surgery.
Psy: In most cases that's not going to happen. And so if that's something that's really important to people they ought to rethink whether they're going to have the surgery.
Patient: Hmm.
Psy: Because a lot of the nerves are cut, the major nerves are cut.
Patient: Right, ok that's fine, its not something that's the be all and end all for me, like again its, you know, having a relationship with somebody and having sensation from sex is, is something that would be nice, but you know if its not possible then I'm quite prepared to have that; I just want my body to be like my mind.

Discussion

Clinical understanding and treatment of transsexualism has had an extraordinary evolution during the past four decades. In the mid-1960s, a US survey of physicians found that most were opposed to sex reassignment surgery, even if the patient had had two years of psychotherapy, was psychiatrically stable in all other areas of functioning, was endorsed for surgery by the treating psychiatrist, and would likely commit suicide were surgery denied (Green et al., 1966).

During the decades, a clinical consensus — the Standards of Care (HBIGDA, 2001) — has evolved for treatment of persons with severe gender dysphoria who may be candidates for sex reassignment. Clinical responsibility requires an appraisal of the patient's motivations for sex-change. Patients have a variety of psychosexual and social histories that may be prognostic for success with sex-change. These factors need to be explored before embarking on the RLE.

Our Clinic oversees patient progression toward possible surgery with the safest, most reversible stages first. Thus, social gender change full-time is required before introducing endocrine somatic change. Male-born patients may argue that without cross-sex steroids the social transition can be handicapped. However, the most visible social stigmata of maleness, voice and facial hair, are modifiable without sex steroid intervention. With the female-born patient, the effects of androgen more clearly enhance social passing as a man early on. However, the effects are more irreversible should the RLE not be fulfilling and the decision made to revert to living as a woman.

The duration of the RLE is controversial. The Standards of Care require a one year minimum. Our Clinic requires two. Some persons describe sex reassignment success with less than one year (Lawrence, 2004). However, in our experience there are patients who change their mind about pursuing sex reassignment surgery during the two-year RLE. For them, to have had surgery before two years would have been catastrophic. Further, the infrequency with which our Clinic can meet with patients after the initial two assessments, 30 min every three months, does not provide ample opportunity to explore all the implications of sex reassignment. Less time would be more undesirable.

Our experience has been that most patients understand the rationale behind Clinic policies. Where they disagree on some elements, clinicians attempt to convey an understanding of their basis. It is housed in concern for the patient's welfare, recognition of the complexity of the issues involved, and an explication that extensive clinical experience supports the cautious protocol.

Clinical and theoretical issues over the psychosexual histories of male-born patients are contentious. They include possible prognostic factors such as the extent to which childhood gender-type behaviours were typical of the same or other sex, whether cross-dressing was sexually arousing, whether sexual attractions have been to same or other birth sex persons, and the extent of success in work typical of a person of that birth sex (Bailey, 2003 ; Blanchard, 1989). Anecdotally, at the Charing Cross Clinic, when we interview a patient or hear of a patient who regrets sex-change, it usually involves a person born male without substantial feminine childhood behaviours, who experienced sexual arousal from cross-dressing, was heterosexually married, with little or no sexual interest in males, and with vocational skills more common among men. Evidence from other programs supports a differential post-sex reassignment outcome of such patient subgroups (Blanchard et al., 1989 ; Doorn et al., 1994 ; Smith et al., 2005). Consequently, the Clinic is more cautious with these patients and maintains strict adherence to a full-time two-year RLE.

Many persons with gender dysphoria, perhaps of the intensity to constitute Gender Identity Disorder (GID), maintain that they do not have a mental disorder and GID should not be listed in the Diagnostic and Statistical Manual of Mental Disorders (APA, 2000) or the International Classification of Diseases (WHO, 1992). Being labelled with a mental illness is seen as stigmatizing and many patients resent having to see a Clinic psychiatrist on the road to sex-change. Some patient advocates argue that GID is a neurodevelopmental

disorder (Reed, 2006), not a psychiatric disorder, and should be removed from the psychopathology sections. There are two responses to these positions. First, in a healthcare delivery system, such as the UK's National Health Service, if GID is removed from the list of disorders, it would lose eligibility for governmental treatment funding. Second, while there is evidence that GID derives from inborn, or biological origins, the evidence is stronger for other disorders in the psychiatry disorder section, such as schizophrenia, autism, and major depressive disorder.

Trawling through the 180 transcribed interviews revealed less overt conflict between patient and clinician than expected based on the reported UK transgender community negativism toward the Clinic. Patients have complained that they are ''not listened to at all and simply have to take what they are given''. A clinician writes: ''Not one of my (14) patients having contact with the (Charing Cross) team there had a single positive thing to say about the process or the consultations'' (West, 2004). Some possible explanations are that the community surveys constitute a biased sample. Patients with more complaints may be more likely to contribute to surveys by community support groups. Possibly, too, patients are cowed during interview to be nonconfrontational. They know that the decisions regarding their long-sought treatments rest with the clinician. They do not want to torpedo progress. They may express their resentments away from the Clinic.

The Clinic hopes to promote better collaboration between patient and clinician as patients strive to reduce gender dysphoria. This is a health care area with exceptional prospect for enhanced well-being, but also with the potential for tragedy. Clinicians and patients share responsibility for enabling a productive partnership.

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